

# IS ERISA READY FOR A NEW GENERATION OF STATE HEALTH CARE REFORM? PREEMPTION, INNOVATION, AND EXPANDING ACCESS TO HEALTH CARE COVERAGE

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## I. INTRODUCTION

On August 26, 2004, the United States Census Bureau reported that 45 million Americans lacked health care insurance in 2003, up by 1.4 million from 2002 and 5.2 million from 2000.<sup>1</sup> The report states that this increase is “statistically significant.”<sup>2</sup>

A national study by the Center for Studying Health System Change released around the same time reported that the percentage of Americans under the age of sixty-five who have employer health insurance dropped from sixty-seven percent to sixty-three percent between 2001 and 2003.<sup>3</sup> As federal legislators work to close the growing health care gap through legislation offering alternatives to employer-provided health care

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1. Peter G. Gosselin, *More Americans in Poverty and Uninsured, Census Says*, SEATTLE TIMES, Aug. 27, 2004, available at [http://seattletimes.nwsources.com/html/nationworld/2002017115\\_poverty27.html](http://seattletimes.nwsources.com/html/nationworld/2002017115_poverty27.html); *Number of Uninsured Americans Rises*, USCHAMBER.COM WEEKLY (U.S. Chamber of Commerce, Washington, D.C.), Aug. 31, 2004, <http://www.uschamber.com/publications/weekly/update/040831.htm>.

2. Press Release, U.S. Census Bureau, Income Stable, Poverty Up, Numbers of Americans With and Without Health Insurance Rise, Census Bureau Reports (Aug. 26, 2004), available at [http://www.census.gov/Press-Release/www/releases/archives/income\\_wealth/002484.html](http://www.census.gov/Press-Release/www/releases/archives/income_wealth/002484.html) (discussing results of CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P60-226, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003 (2004), available at <http://www.census.gov/prod/2004pubs/p60-226.pdf>).

3. BRADLEY C. STRUNK & JAMES D. RESCHOVSKY, TRENDS IN U.S. HEALTH INSURANCE COVERAGE, 2001–2003 1 (Ctr. for Health Sys. Change, Tracking Report No. 9, 2004), <http://www.hschange.com/CONTENT/694/694.pdf>.

coverage,<sup>4</sup> the states have reentered the health care reform arena armed with innovative ideas and recent Supreme Court opinions that narrow the reach of the Employee Retirement Income Security Act of 1974 (ERISA)<sup>5</sup> preemption provisions. In fact, as of June 2005, bills pending in thirty-one states look to employers for solutions to the pervasive problem of the uninsured.<sup>6</sup> Since its passage in 1974, ERISA has had a profound effect on state health care law because ERISA section 514 preempts all state laws that “relate to” employee benefit plans save a few narrow exceptions.<sup>7</sup> One of these exceptions allows the states to continue to regulate insurance. This exception, within the “Savings Clause,”<sup>8</sup> has allowed the states to have

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4. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (creating a prescription drug benefit and additional health care plan options for Medicare); Harvey S. Rosen, Chairman, Council of Econ. Advisors, Comments on Health Care at the Conference of the National Association of Business Economics 9 (Mar. 21, 2005), *available at* <http://www.whitehouse.gov/cea/nabe-healthcare032105.pdf> (discussing various government proposals that address current health care concerns); Press Release, The White House, Fact Sheet: Expanding Access and Increasing the Affordability of Health Insurance Through Health Savings Accounts (Aug. 9, 2004), *available at* <http://www.whitehouse.gov/news/releases/2004/08/20040809-14.html> (discussing Medicare bill that “establishes new tax-free savings accounts for individuals and groups who purchase affordable high-deductible health plans”).

5. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 & 29 U.S.C.).

6. The pending bills take three general forms: (1) model using incentives or penalties to cause employers to bear more of the health care costs of their employees (“employer inducements”), (2) model conditioning state benefits and contracts on provision of health care to employees (“conditioning state benefits”), and (3) model including reporting requirements designed to identify employers in the state failing to bear their fair share of health care costs (“reporting requirements”). The bills can be broken down into the above-described categories as follows: EMPLOYER INDUCEMENTS: Arizona (HB 2545, SB 1471), Connecticut (SB 1147), Maryland (HB 1284, SB 790) (passed and vetoed), Massachusetts (SB 743), Nevada (AB 87, BDR 1110), New Hampshire (HB 633, LSR 423), New Jersey (A4088), New York (AB 4129), Oregon (SB 764, SB 820), Tennessee (HB 127 & SB 383, HB 1363 & SB 884), Washington (HB 1702, SB 5637); CONDITIONING STATE BENEFITS: Connecticut (HB 5976), Georgia (HB 389), Maine (LD 546, SP 172), Mississippi (HB 1682), New Jersey (AB 574, SB 2121), Oklahoma (HB 1353), Tennessee (HB 125, SB 384), Texas (HB 1496, HB 1499, SB 770), Utah (SB 66), Vermont (HB 293, HB 358), Washington (HB 1527, HB 2220); REPORTING REQUIREMENTS: These bills are so numerous that I will simply list the states that have proposed them: Alabama, Arizona, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Maryland, Minnesota, Missouri, Nevada, New Mexico, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Virginia. For a similar breakdown of pending state legislation, see HR Policy Ass’n, Policy Brief, Pressure Building at State Level to Compel Employers to Provide Health Insurance Coverage (Sept. 28, 2005), [http://www.hrpolity.org/memoranda/2005/05-33\\_State\\_Mandate\\_PB.pdf](http://www.hrpolity.org/memoranda/2005/05-33_State_Mandate_PB.pdf).

7. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)(2000) (“Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”).

8. *Id.*

some regulatory control over employer provided health benefit plans that are administered through insurance carriers (“insured plans”), while benefit plans that are funded by the employer (“self-insured plans”) are exempt from almost all state regulation. As the Supreme Court has narrowed the scope of ERISA preemption in the last ten years by expanding the scope of the “Savings Clause,” the regulatory gap between insured and self-insured plans has widened. While the contraction of ERISA preemption offers more opportunities for state regulators to confront the problem of the growing number of working uninsured through insurance regulation, it also creates incentives for employers to establish self-insured plans specifically to avoid state regulation, even when the employer is incapable of providing sufficient benefits through self-insurance. One particular state initiative that has the potential to realign the interests of regulators and employers is a legislative scheme referred to colloquially as “pay-or-play” or “fair share” legislation,<sup>9</sup> which essentially mandates that all or a particular class of employers dedicate more resources to providing health care coverage to their employees. The pay-or-play model allows employers to control how health care dollars are spent while compelling them to bear their fair share of the health care costs that uninsured employees ultimately pass along to the state. To date, only two states, California and Massachusetts, have successfully enacted a pay-or-play law, but both of those laws were repealed before they became effective. Similar legislation passed by the Maryland state legislature was vetoed by the Governor on May 19, 2005, but the legislature overrode the veto in January 2006.<sup>10</sup> Consequently, the implications of ERISA in the context of this new genre of state health care reform are as yet untested. However, if the analysis employed by the Supreme Court in the seminal cases<sup>11</sup> expanding the “Savings Clause” is

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9. See PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, REVISITING PAY OR PLAY: HOW STATES COULD EXPAND EMPLOYER-BASED COVERAGE WITHIN ERISA CONSTRAINTS (2002) [hereinafter BUTLER, REVISITING PAY OR PLAY, available at [http://www.nashp.org/Files/ERISA\\_pay\\_or\\_play.pdf](http://www.nashp.org/Files/ERISA_pay_or_play.pdf) (discussing and proposing suggestions for state pay-or-play laws that would withstand ERISA preemption challenges).

10. During the final production stages for this Article, the Maryland Legislature overrode Governor Ehrlich’s veto on January 12, 2006. The Senate voted 30-to-17 and the House voted 88-to-50 in favor of the bill. See John Wagner, *Maryland Legislature Overrides Veto on Wal-Mart Bill*, WASH. POST, Jan. 13, 2006, at A1. Labor leaders predict that the success of the Maryland bill will build momentum in thirty-one other states currently considering similar bills. See Amy Joyce & Matthew Mosk, *Unions Hope Wal-Mart Bill has Momentum*, WASH. POST, Jan. 14, 2006, at D1. Wal-Mart, the only employer in Maryland implicated by the FSHCA, has indicated that it may challenge the legality of the new law. A Wal-Mart spokeswoman told the Washington Post that both the Maryland Chamber of Commerce and the United States Chamber of Commerce have questioned whether the law could survive an ERISA preemption challenge. Tom Stuckey, *Wal-Mart Mulls Legal Challenge to Md. Law*, WASH. POST, Jan. 13, 2006, available at <http://www.washingtonpost.com/wpdyn/content/article/2006/01/13/AR2006011301291.html> (last visited Jan. 27, 2006).

11. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (holding that “Any

applied to a general interpretation of what “relate[s] to” an ERISA plan under section 514(a), there seems to be a significant chance that certain formulations of the pay-or-play model do not trigger ERISA preemption. Thus, before delving into the merits of pay-or-play legislation,<sup>12</sup> it makes sense to determine which of the currently available drafts of the pay-or-play model, if any, are capable of surviving an ERISA preemption challenge.

The purpose of this Article is to discover the limitations, if any, ERISA imposes on pay-or-play legislation. Part II provides a general background to ERISA section 514<sup>13</sup> and discusses preemption jurisprudence from 1974 through 1995. Part III explores the Supreme Court’s 1995 decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*<sup>14</sup> and the implications of that decision for the scope of ERISA preemption. Part IV considers three legislative schemes designed to increase employer provision of health benefits: (1) a blanket mandate that employers provide health benefits to their employees; (2) the basic pay-or-play model employed by the California Health Insurance Act of 2003 (HIA) and the Maryland Fair Share Health Care Act of 2005 (FSHCA); and (3) the tax and tax credit model of pay-or-play employed by the Massachusetts Health Security Act of 1988 (HSA). The conclusion reached is that (1) even after the *Travelers Insurance* decision, ERISA preempts a general state mandate that employers provide health care benefits for employees, (2) the California version of pay-or-play<sup>15</sup> is also very likely preempted by ERISA because it mandates specific benefits and plan administration, and (3) the Maryland

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Willing Provider” provisions of Kentucky Health Care Reform Act were laws regulating insurance and saved from ERISA preemption); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding that an HMO plan was not preempted by ERISA); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (holding that statutes providing for surcharges on hospital rates did not “relate to” benefit plans under ERISA and therefore were not preempted).

12. Although there is an abundance of commentary available on the merits of pay-or-play legislation, one study prepared in 2003 for the California HealthCare Foundation on the potential impact of a tax credit for employers in California is particularly interesting. See KARL PULZER & JONATHAN GRUBER, CAL. HEALTHCARE FOUND., ASSESSING THE IMPACT OF STATE TAX CREDITS FOR HEALTH INSURANCE COVERAGE (2003), available at <http://www.chcf.org/documents/insurance/TaxCreditsBrief.pdf> (concluding that tax credits do not address all problems related to employee health coverage but are a step in the right direction).

13. ERISA § 514(a), 29 U.S.C. § 1144(a):

Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b) . . . .

14. 514 U.S. 645 (1995).

15. California Health Insurance Act of 2003, 2003 Cal. Stat. 673.

and Massachusetts versions of pay-or-play appear to avoid ERISA preemption by circumlocuting any express reference to benefits or plan administration.

## II. ERISA PREEMPTION: BACKGROUND 1974–1995

### A. *A Brief History of ERISA and Section 514*

In the early 1970s, Congress proposed a federal regulatory scheme to replace the muddle of state pension plan regulations that failed to stave off the corruption and mismanagement that led to the collapse of numerous employer-sponsored pension funds.<sup>16</sup> In the process of drafting, Congress expanded this legislation, ERISA,<sup>17</sup> to also preempt state laws relating to any “employee benefit plan,” including health and welfare benefit plans.<sup>18</sup> Congress also dramatically broadened the scope of ERISA preemption by rewriting a first draft<sup>19</sup> that “defined the perimeters of preemption in relation to the areas regulated by the bill”<sup>20</sup> as a catch-all provision with enumerated exceptions. Ironically, Senator Javits, who was a principal author of ERISA, explained the drafting change as an attempt to prevent litigation over the meaning of the scope of the clause.<sup>21</sup> What seems clear is that the change from preempting only those “subject matters regulated by [ERISA]” to all subject matters that “relate to” employee benefit plans,

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16. The closing of the Studebaker automobile plant in South Bend, Indiana, is generally regarded as a pivotal event in the history of the movement toward comprehensive federal regulation of private pension plans. Due to mismanagement and redirection of pension funds into the sinking company, thousands of Studebaker workers lost most or all of their pensions. The number of persons affected by the termination attracted attention, since the plan covered almost 11,000 Studebaker employees. The average age and length of service of the workers who received only a small percentage of their expected pension benefits made them a very sympathetic group of victims. The 4,000 or so workers in the age 40–59 group who got only fifteen cents for every expected dollar of vested pension benefits, had an average age of 52 and an average period of service with the employer just under 23 years.

17. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 & 29 U.S.C.).

18. ERISA § 3(1), 29 U.S.C. § 1002(1) (2000).

19. The prior version of section 514(a) would have preempted state laws only “insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans” or “insofar as they may now or hereafter relate to the subject matters regulated by this Act.” H.R. 2, 93d Cong. (1973), *reprinted in* I SENATE COMM. ON LABOR & PUBLIC WELFARE, LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 51 (1976) [hereinafter LEGISLATIVE HISTORY].

20. Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 620 (1994) (quoting 120 CONG. REC. 29,942 (1974), *reprinted in* III LEGISLATIVE HISTORY, *supra* note 19, at 4770–71 (statement of Sen. Javits)).

21. 120 CONG. REC. 29,942 (1974), *reprinted in* III LEGISLATIVE HISTORY, *supra* note 20, at 4770–71 (1976).

save insurance, banking, and investment laws, was a conscious decision to broaden the section's scope. The significant effect of a provision worded as "all, but" is that it implies preemption should be presumed unless an exception is established. In the last ten years, the Supreme Court has rejected this implication on the grounds that federal preemption should never be presumed.<sup>22</sup> The Court has slowly chipped away at the breadth of ERISA preemption both by narrowing what "relate[s] to" an employee benefit plan and by expanding the enumerated exceptions in the "Savings Clause." The major changes, however, have only occurred in the context of the "Savings Clause" and thus it remains unclear what sort of indirect regulation outside of the areas enumerated in the "Savings Clause" are still thought to "relate to" plans and thereby trigger preemption.

The scope of ERISA preemption in the context of health and welfare plans is particularly significant because, as one commentator points out, unlike ERISA's expansive regulation of pension plans, it provides relatively little substantive regulation of health plans.<sup>23</sup> The result is that health plans governed by ERISA can be structured to go largely unregulated. I mention structure here because the "Savings Clause"<sup>24</sup> allows the states to exercise some regulatory control over the provision of benefits and the administration of health plans. However, the following provision, the "Deemer Clause,"<sup>25</sup> makes clear that employee health benefit funds governed by ERISA are not insurance companies, although they often serve an insurance function. Thus, a plan that is structured to provide benefits through an insurance company can, in effect, be regulated indirectly by state insurance law, whereas a plan that is "self-insured," meaning it directly provides participants with benefits, is almost completely unregulated. The regulatory gap between insured and self-insured plans was likely not an issue discussed when section 514 was rewritten in conference committee. "There were apparently few self-

22. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 654-55 (1995) (citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)). For a more general discussion of federal preemption, see Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994).

23. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 92 (2005).

24. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A):

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulated insurance, banking, or securities.

25. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B):

Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company . . . .

insured plans in the early 1970s. The Health Insurance Association of America has estimated that only four percent of health benefits were paid under [self-insured] plans in 1976, in contrast to between thirty-three and fifty percent in recent years.”<sup>26</sup> As the Supreme Court has interpreted the “Savings Clause” more broadly, allowing for increased indirect regulation of insured plans, the regulatory gap between insured and self-insured plans has become substantial. The question today is whether the Supreme Court’s willingness to contract the scope of ERISA preemption in the context of the “Savings Clause” extends to the general reach of “relate to” under section 514(a).<sup>27</sup> The regulatory gap between insured and self-insured health plans is the uncharted legal terrain into which the pay-or-play law boldly ventures. Predicting whether pay-or-play laws are capable of surviving an ERISA preemption challenge under section 514 requires answering the above-posed question about the extension of the Supreme Court’s more recent “Savings Clause” jurisprudence. The following Subparts explore the evolution of Supreme Court ERISA preemption jurisprudence from the passage of ERISA in 1974 until the seminal decision in *Travelers Insurance* in 1995.

#### B. *Preemption of Health Care Mandate Laws in Hawaii and California*

Two of the earliest ERISA preemption cases concerned health plan regulation under California’s Knox-Keene Act of 1975 and the Hawaii Prepaid Health Plan Act of 1974. The California statute required health plans to cover certain services and the Hawaii employer mandate defined required benefits for health plans and dictated terms of employer contributions to plans. In *Hewlett-Packard v. Barnes*<sup>28</sup> and *Standard Oil Co. of California v. Agsalud*,<sup>29</sup> the Court of Appeals for the Ninth Circuit held that both laws were preempted by ERISA because they “related to” and directly affected health benefit plans.<sup>30</sup> The Supreme Court affirmed the *Agsalud* decision in a memorandum opinion<sup>31</sup> and thereby sanctioned the Ninth Circuit’s ERISA preemption analysis.

In *Agsalud*, the Ninth Circuit Court of Appeals held that ERISA preempted all state law “relating to the administration of [benefit] plans, particularly with respect to disclosure, reporting, vesting of benefits,

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26. PATRICIA A. BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICYMAKERS 18, (2000) (citations omitted), available at <http://www.statecoverage.net/pdf/erisa2000.pdf> [hereinafter BUTLER, ERISA PREEMPTION].

27. See *supra* note 7 and accompanying text.

28. 571 F.2d 502 (9th Cir. 1978).

29. 633 F.2d 760 (9th Cir. 1980).

30. *Hewlett-Packard*, 571 F.2d at 505; *Agsalud*, 633 F.2d at 766.

31. *Agsalud v. Standard Oil Co. of Cal.*, 454 U.S. 801 (1981).

funding and the conduct of plan managers.”<sup>32</sup> The court held that the Hawaii law, which mandated that employers in the state provide their employees with a comprehensive prepaid healthcare plan, “directly and expressly regulate[d] . . . employee benefit plans within the meaning of ERISA’s broad preemption provision.”<sup>33</sup> Congress eventually exempted from ERISA’s preemption clause Hawaii’s Prepaid Health Care Act (HPHCA) and any post-September 1974 amendments to the HPHCA that provide for the effective administration of the Act.<sup>34</sup> In 1994, Oregon attempted to acquire a similar exemption for an employer health care mandate enacted in that state, but no such exemption was granted and the law was repealed.<sup>35</sup> It is important to note that Hawaii’s exemption is not based on the substance of the HPHCA, but on the determination by Congress that post-September 1974 amendments to the HPHCA related back to the original Act which pre-dated ERISA and was therefore exempt from preemption.<sup>36</sup>

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32. *Agsalud*, 633 F.2d at 763.

33. *Id.* at 766 (citation omitted).

34. 29 U.S.C. § 1144(b)(5)(A) (2000).

35. See BUTLER, REVISITING PAY OR PLAY, *supra* note 9, at 4–5:

In 1989, Oregon enacted an employer pay or play program (although sponsors and the legislative intent clause also referred to it as an employer mandate). The law imposed a payroll tax on employers who had not provided employee and dependent coverage. [The tax was equal to 75 percent of the cost of a basic benefits package (to be defined by the state agency) for employee coverage and 50 percent of this cost for dependent coverage. The law also provided tax credits for small employers that began to cover their workers.] The fund created with these tax revenues would be used by the state to buy health coverage for these employers’ uninsured employees and dependents. In contrast to the Massachusetts law, the Oregon tax applied only to employers *not* covering their workers.

In recent years, several states have considered similar legislation but not enacted these proposals. In 1998, as part of a minimum wage increase, the Washington legislature considered permitting employers to pay a lower minimum wage if they financed an acceptable level of health coverage. In 2000, a Tennessee bill declared that “the primary source of health insurance for employed individuals should be an employer-sponsored health insurance plan,” and would have imposed a tax on the gross revenue of employers that did not cover their workers. A legislative proposal discussed in Maryland in 2000 would have created a universal coverage program, financed in part by a payroll tax but allowing employers to opt out by continuing to cover their employees with benefits prescribed by state law.

36. 29 U.S.C. § 1144(b)(5)(A) (2000).



C. *ERISA Preemption Analysis: “Relate to,” “Refers to,” “Connection with,” and “Tenuous Connection” to ERISA Plans*

In the fifteen years following the Ninth Circuit’s opinion in *Agsalud*, the Supreme Court’s ERISA preemption jurisprudence elaborated on the simple prohibition advanced by the Ninth Circuit. In 1983, the Court decided *Shaw v. Delta Air Lines, Inc.*,<sup>37</sup> holding that a state law “relates to” an employee benefit plan, in the normal sense of the phrase, if it has a “connection with” or “reference to” such a plan.<sup>38</sup> The *Shaw* analysis, which dominated federal ERISA preemption jurisprudence for over a decade, set forth a bifurcated approach to ERISA preemption. First, a state law “relates to” an ERISA plan if it makes any *reference to* such a plan.<sup>39</sup> Second, a state law “relates to” an ERISA plan if the substance of the law has a *connection with* such a plan.<sup>40</sup> Explaining the statutory phrase “relates to” as carrying a meaning tantamount to “a connection with” did little to clarify the meaning of section 514 beyond suggesting that the Court was adopting an expansive interpretation of that language. The Court in *Shaw* did, however, suggest in a footnote that “[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”<sup>41</sup> *Shaw* has been cited by subsequent cases primarily to support three propositions:

(1) “relate to,” as that phrase is used in ERISA section 514, should be understood to mean either making *reference to* or having a *connection with*;

(2) Congress intended to use the phrase “relate to” in the broadest sense; and

(3) some connections with ERISA plans may be too tenuous and remote to trigger preemption under section 514.

In *Mackey v. Lanier Collection Agency & Service, Inc.*<sup>42</sup> the Supreme Court relied upon *Shaw* to strike down a Georgia law that gave special treatment to ERISA plans under the state’s garnishment procedures. The

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37. 463 U.S. 85 (1983).

38. *Id.* at 86 (holding that New York Human Rights Law, N.Y. EXEC LAW §§ 290–301 (1982), which was a comprehensive anti-discrimination statute prohibiting, among other practices, employment discrimination on the basis of sex, was preempted by ERISA section 513 to the extent that the law required employers to extend sick-leave benefits to employees unable to work because of pregnancy).

39. *Id.* at 97.

40. *Id.*

41. *Id.* at 100 n.21.

42. 486 U.S. 825 (1988).

Court in *Mackey* held that, despite the fact that the Georgia law singled out ERISA plans to protect them, seemingly in accordance with the legislative intent behind ERISA preemption, the law was still preempted by ERISA section 514 because it made "reference to" ERISA plans explicitly.<sup>43</sup> Justice White, writing for the majority in *Mackey*, held that "adhering to . . . precedents in this area" required the Court to find that "state laws which make 'reference to' ERISA plans are laws that 'relate to' those plans within the meaning of § 514(a)."<sup>44</sup> Significantly, and as will be discussed later in more detail, the Court in *Mackey* upheld the Georgia garnishment law as it applied generally to ERISA plans.<sup>45</sup> The Court only struck down that portion of the law which gave certain preferential exemptions to ERISA plans. Thus, that portion of the *Mackey* opinion which held that the preferential treatment section of the Georgia garnishment law<sup>46</sup> was preempted by ERISA section 514(a) came to stand for the proposition that any explicit reference to benefit plans in a state law was grounds for federal preemption.

Drawing on the interpretation of *Shaw* in *Mackey*, the Supreme Court in 1992 decided *District of Columbia v. Greater Washington Board of Trade*,<sup>47</sup> holding that a D.C. law requiring employers that offered health insurance coverage to their employees to provide equivalent coverage to their employees while receiving workers compensation benefits<sup>48</sup> was preempted under ERISA section 514(a) because it *referred to* ERISA plans explicitly.<sup>49</sup> Justice Thomas, writing for the majority, held that "[s]ection 2(c)(2) of the District's Equity Amendment Act specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted."<sup>50</sup>

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43. *Id.* at 829–30.

44. *Id.* at 829 (citing *Shaw*, 463 U.S. at 96–97).

45. *Id.* at 841.

46. GA. CODE § 18-4-22.1 (1982).

47. 506 U.S. 125 (1992). For Supreme Court decisions employing substantially similar analysis, see *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

48. D.C. CODE ANN. § 36-307(a-1)(1) (1992).

49. 506 U.S. at 129 ("We have repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.'" (quoting *Shaw*, 463 U.S. at 97)).

50. *Id.* at 130. There is currently one important exception to the rule that direct reference to ERISA plans will cause a state law to be preempted. In *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 335 (2003), the Supreme Court held that Kentucky's "any willing provider" law was not preempted by ERISA despite the fact that it directly referred to ERISA plans because the law dealt directly with insurance companies and was therefore saved from preemption under ERISA's "savings clause," ERISA § 514(b). The law referred directly to ERISA plans by specifically exempting self-funded ERISA plans. *Id.* Although significant, this case is not relevant for the discussion here

### III. TRAVELERS AND BEYOND: THE SUPREME COURT CONTRACTS THE SCOPE OF ERISA PREEMPTION

In its 1995 *Travelers Insurance* decision, the Supreme Court narrowed the reach of ERISA's preemption provisions by limiting the category of state law impacts on ERISA plans that qualify as "relat[ing] to" ERISA plans under section 514.<sup>51</sup> The Court explicitly diverged from its prior preemption jurisprudence, writing, "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here."<sup>52</sup> Some commentators have suggested that the most important aspect of *Travelers Insurance* is the Court's recognition of the ineffectiveness of prior ERISA preemption analysis.<sup>53</sup> Because of this express divergence from precedent, all ERISA preemption analysis, not just "Savings Clause" analysis, should be viewed through the lens of the *Travelers Insurance* decision.

*Travelers Insurance* held that ERISA did not preempt a state law imposing surcharges on certain insurers' hospital bills because the state law was not directed specifically at health plans but rather was a law of general application within one of the states' traditional areas of authority (hospital rate setting).<sup>54</sup> In analyzing ERISA's preemption provisions, the Court observed that, taken literally, the words "relate to" have no logical limitation. The court determined that despite the breadth of the preemption provisions, federal preemption is disfavored and should be construed only

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because it only applies to laws directed at the insurance industry. For more discussion on Kentucky's "any willing provider" law and the *Kentucky Assoc. of Health Plans* case, see PATRICIA A. BUTLER, NATIONAL ACADEMY FOR STATE HEALTH POLICY, KENTUCKY'S "ANY WILLING PROVIDER" LAW AND ERISA: IMPLICATIONS OF THE SUPREME COURT'S DECISION FOR STATE HEALTH INSURANCE REGULATION (2003), available at [http://www.nashp.org/files/GNL51\\_ERISA.pdf](http://www.nashp.org/files/GNL51_ERISA.pdf) [hereinafter "ANY WILLING PROVIDER"].

51. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

52. *Id.* at 655.

53. The Court here may have been addressing the Second Circuit Court of Appeals remark in the preceding determination that ERISA section 514 was "a veritable Sargasso Sea of obfuscation." *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993), *rev'd sub nom.* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). See BUTLER, REVISITING PAY OR PLAY, *supra* note 9, at 3; BUTLER, ERISA PREEMPTION, *supra* note 26; James Saya, Note, *Removing a Roadblock to Reforming Health Care*: New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company, 3 CONN. INS. L.J. 127, 157 (1996); Rebecca S. Fellman-Caldwell, Note, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: The Supreme Court Clarifies ERISA Preemption*, 45 CATH. U. L. REV. 1309, 1328-29 (1996).

54. The New York law required commercial insurers to pay a surcharge on hospital bills, but exempted BlueCross/BlueShield plans from paying this extra cost because of their higher risk case load as the state's insurer of last resort. *Travelers Ins.*, 514 U.S. at 649.

as broadly as appropriate to effect congressional intent.<sup>55</sup> In the case of ERISA section 514(a), the Court determined that Congress intended to subject employee benefit plans to a uniform body of benefit laws and minimize the administrative and financial burdens of complying with conflicting state and local requirements.<sup>56</sup> Even though the Court concluded that the surcharges might have an indirect economic effect on plan choices, it determined they would not compel plan administrators to structure benefits in any particular way or limit a plan's ability to have uniform benefits packages or uniform administrative practices across state boundaries.<sup>57</sup> The Court explicitly acknowledged state authority to regulate health care,<sup>58</sup> noted that the fact that hospital and other health care costs vary across states does not create an ERISA problem, and asserted that Congress could not have intended to preempt the many types of state health care regulations, such as quality standards or workplace regulations, that indirectly impose costs on ERISA health plans.<sup>59</sup> In conclusion, Justice Souter, writing for a unanimous Court, held that a law of general applicability, which necessarily has indirect economic influence over an ERISA plan, "does not bind plan administrators to any particular choice"<sup>60</sup> and is thus not a regulation of ERISA plans themselves and therefore not preempted. The Court clarified that it was not holding that only direct regulation of ERISA plans,<sup>61</sup> which I can only assume means direct reference to some facet of ERISA plans, are preempted. The Court wrote,

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55. See LEGISLATIVE HISTORY, *supra* note 19, and accompanying text.

56. *Travelers Ins.*, 514 U.S. at 656.

57. *Id.* at 656–62.

58. *Id.* at 655.

59. *Id.* at 647.

60. *Id.* at 659–60:

An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself; commercial insurers and HMO's may still offer more attractive packages than the Blues. Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

61. *Id.* at 668 (citations omitted):

That said, we do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.

“[i]t is possible that a state law might produce such acute, albeit indirect, economic effects as to force an ERISA plan to adopt a certain scheme of coverage or effectively restrict its choice of insurers” so as to be preempted.<sup>62</sup> This bit of dicta makes clear that state regulation that indirectly effects ERISA plans might still be preempted if the effect on plans undermines the purpose of ERISA preemption.

To summarize, the Court in *Travelers Insurance* made several significant points about ERISA preemption:

- A finding of preemption is disfavored.<sup>63</sup>
- The Court will work with the assumption that Congress did not intend to preempt traditional areas of state regulation.<sup>64</sup>
- Preemption claims “turn on Congress’s intent.”<sup>65</sup>
- Indirect economic influence on the choices made by ERISA plan administrators is not alone a “connection with” ERISA plans sufficient to trigger preemption.<sup>66</sup>
- A state law with indirect economic effects on ERISA plans might be preempted if those effects are so acute as to dictate plan administration and/or coverage.<sup>67</sup>

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62. *Id.*

63. *Id.* at 654–55 (“[W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.” (citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981))).

64. *Id.* at 655 (citations omitted):

Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the “assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”

65. According to the Court in *Travelers Ins.*, congressional intent behind ERISA was:

“to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.”

*Id.* at 656–57 (quoting *Ingersoll-Rand v. McGlendon*, 498 U.S. 133, 142 (1990)).

66. See discussion *supra* Part II.C.

67. *Id.*

The *Travelers Insurance* decision has been treated by commentators as a prime example of the current Supreme Court's interest in realigning the federal balance more on the side of the states.<sup>68</sup> According to the Pension and Benefits Reporter, the *Travelers Insurance* decision amounts to "an open invitation for states to become creative in using different kinds of assessments to pay for health care."<sup>69</sup>

The flow chart on the following page is an attempt to illustrate a current framework for ERISA preemption analysis after the *Travelers Insurance* decision.

#### IV. STATE MODELS DESIGNED TO CLOSE THE REGULATORY GAP BETWEEN INSURED AND SELF-INSURED PLANS AND TO COMPEL EMPLOYERS TO PAY THEIR "FAIR SHARE" OF HEALTH CARE COSTS

State health policymakers describe the pay-or-play model generally as a method to "reduce the number of uninsured people while distributing the costs of health care coverage more equitably," through the imposition of "a tax on all [or certain] employers that is used to fund coverage under a public program while allowing a credit for employee health coverage costs."<sup>70</sup> While this generally describes all pay-or-play laws, the states that are experimenting with pay-or-play have formulated two different versions of this tax. First, California and Maryland have devised legislative schemes that condition imposition of the tax on employer health care expenditure. The tax in that model functions almost like a fine for inadequate provision of employee health care. The other version of pay-or-play is the tax and tax credit scheme devised by the Massachusetts state legislature in the late 1980s. In this instance, the tax is truly generally applicable and designed to fund public provision of health care to the uninsured. The tax credit functions like a subsidy for employer-sponsored health care. Although all three laws have differing features and structures, all three essentially seek to encourage or even compel employers to provide some health care coverage to the thirty-eight percent of working Americans who are currently uninsured.<sup>71</sup> Before evaluating the various formulations of the pay-or-play law that were designed specifically to avoid ERISA preemption, it makes sense to explore whether the scope of ERISA preemption after *Travelers Insurance* even reaches a general state mandate

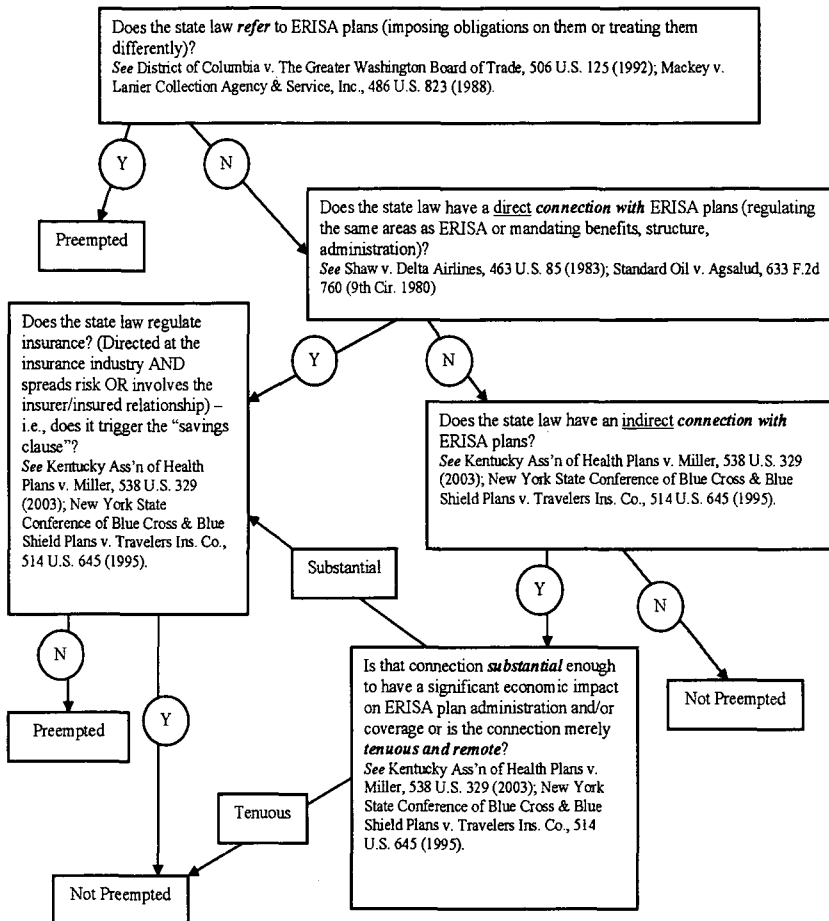
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68. See, e.g., Fellman-Caldwell, *supra* note 53, at 1309.

69. *Experts Divided over Impact of U.S. Supreme Court ERISA Decision*, 22 Pens. & Ben. Rep. (BNA) No. 23, at 1348 (June 5, 1995).

70. BUTLER, REVISITING PAY OR PLAY, *supra* note 9, at 1.

71. Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2003 Annual Survey, <http://www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Full-Report.pdf>.



that employers provide unspecified health care coverage to all employees.

A. *A General Mandate that Employers Provide Health Benefits*

The case could be made that interpretation of the ERISA preemption clause in light of the *Travelers Insurance* opinion indicates potentially different treatment of a blanket state mandate that employers provide health benefits to employees. Consider that there are four relevant references to “mandates” in *Travelers Insurance* and all express the opinion that state mandates are preempted by ERISA, but all four references qualify the term “mandate” with some specific scheme of benefits or plan administration.<sup>72</sup> Similarly, in the only Supreme Court case citing the *Agsalud* opinion,<sup>73</sup> the HCHPA is referenced by both the majority and dissent as an impermissible state mandate of particular benefits and plan administration that would subject a plan to divergent regulation in different states.<sup>74</sup> Significantly, the

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72. “Thus, ERISA pre-empts state laws that mandate employee benefit structures or their administration as well as those that provide alternative enforcement mechanisms.” *Travelers Ins.*, 514 U.S. at 648, “. . . by imposing reporting and disclosure mandates.” *Id.* at 651.

These mandates affecting coverage could have been honored only by varying the subjects of a plan’s benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary.

*Id.* at 657. “Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate . . .” *Id.* at 664.

73. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 23 (1987) (upholding a Maine statute requiring employers to provide employees with a one-time severance payment when a plant closes, on the grounds that this benefit was not a benefit plan under the meaning in ERISA).

74. *Id.* at 12–13:

The Hawaii law was struck down, for it posed two types of problems. First, the employer in that case already had in place a health care plan governed by ERISA, which did not comply in all respects with the Hawaii Act. If the employer sought to achieve administrative efficiencies by integrating the Hawaii plan into its existing plan, different components of its single plan would be subject to different requirements. If it established a separate plan to administer the program directed by Hawaii, it would lose the benefits of maintaining a single administrative scheme. Second, if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs. *Agsalud* thus illustrates that whether a State requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same. Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all.



*Travelers Insurance* opinion distinguishes “indirect economic effect[s]” on the grounds that such effects or influence do “not bind plan administrators to any particular choice” or “preclude uniform administrative practice or the provision of a uniform interstate benefit package.”<sup>75</sup> These cases suggest that the Court has identified the removal of plan administrative independence and lack of uniform regulation across state lines as the primary evils resulting from state mandates that ERISA sought to eliminate. Thus, neither *Travelers Insurance* nor *Fort Halifax* (discussing *Agsalud*) directly address the issue of a general state mandate that employers provide health benefits to their employees.

Furthermore, and significantly, the *Mackey* decision, which relies upon the Court’s expansive reading of ERISA section 514(a) in *Shaw*, upheld a Georgia law of general applicability even though it would directly effect benefit plans in its enforcement.<sup>76</sup> The Georgia garnishment law allowed judgments to be enforced by garnishing plan benefits to satisfy a money judgment against a beneficiary.<sup>77</sup> The Court in *Mackey* explained:

It is not incongruous to find that Ga. Code Ann. § 18-4-20, which provides for garnishment of ERISA welfare benefit plans, escapes pre-emption under ERISA, while striking down § 18-4-22.1—an exception to the general state-law provision—as pre-empted. While we believe that state-law garnishment procedures are not pre-empted by § 514(a), we also conclude that *any* state law which singles out ERISA plans, by express reference, for special treatment is pre-empted. It is this “singling out” that pre-emptes the Georgia antigarnishment exception.<sup>78</sup>

However, while the Supreme Court’s decision in *Travelers Insurance* seems to affect at least some state laws that indirectly affect employer-sponsored health coverage, it seems very likely that ERISA still prohibits state attempts to mandate that employers offer health insurance and other state laws directed explicitly at employer-sponsored health plans.<sup>79</sup> *Travelers Insurance* seems to have left intact the strict analysis for state laws making “reference to” ERISA plans set forth in *Shaw* and *Greater Washington Board of Trade*. Justice Thomas made it clear in *Greater Washington Board of Trade* that simple reference in a state law to ERISA plans would subject that law to preemption.<sup>80</sup> The *Travelers Insurance* decision cited this very proposition when explaining the breadth of the

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75. *Travelers Ins.*, 514 U.S. at 659.

76. See *Mackey v. Lanier Collection Agency & Serv. Inc.*, 486 U.S. 825, 829 (1988).

77. *Id.* at 827–28.

78. *Id.* at 838 n.12 (citation omitted).

79. This is also the conclusion of the National Academy for State Health Policy. See BUTLER, REVISITING PAY OR PLAY, *supra* note 9; BUTLER, ERISA PREEMPTION, *supra* note 26.

80. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992).

phrase “relates to” in the preemption clause.<sup>81</sup> Although a general mandate that employers provide health benefits does not expressly address ERISA plans, the argument can easily be made that the mandatory provision of benefits is tantamount to (1) requiring the creation of ERISA plans and (2) mandating the maintenance of ERISA plans. In fact, execution of a state mandate could have no alternative result, nor could it have an alternative purpose. There is no reason to assume that the Supreme Court would not interpret an employer mandate as it is naturally interpreted and conclude that such a mandate is purposeful interference with ERISA plans. Thus, the direct effect on ERISA plans that is necessarily a part of a general mandate and the Supreme Court’s stated disdain for state “mandates” make it unlikely that a state law compelling employers to provide health care benefits, however general, would avoid preemption.

### *B. The Pay-or-Play Model*

#### *1. The California Employer Pay-or-Play Act of 2003*

California’s Health Insurance Act of 2003,<sup>82</sup> mandated that medium employers (those with twenty to 199 employees in California) and large employers (those with 200 or more employees in California) either offer a minimum level of health care coverage to their employees or pay a “fee” to the state to fund a state-run health insurance program, designated the State Health Purchasing Program. The “minimum level of health coverage” included mandates on who should qualify as an eligible enrollee<sup>83</sup> and what type of coverage should be provided. The Act calculated the “fee” due to the state insurance program according to the number of uninsured employees an employer employed who would have been eligible for coverage if that employer was in compliance with the terms of the Act.<sup>84</sup>

There are several glaring preemption problems with the California law. First of all, the law is designed to make the “fee” an overt penalty for non-compliance with the other terms of the law. The simple use of the term “fee” and the punitive structure of the law are likely to prevent successful analogy to laws having only an indirect effect on ERISA plans. This problem is further complicated by the fact that the penalty is calculated directly based on the number of uninsured employees in an

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81. *Travelers Ins.*, 514 U.S. at 655–56.

82. 2003 Cal. Stat. 673; California Senate Bill 2.

83. The Act mandated that employers with more than 200 employees in the state extend coverage to employees’ dependents and provided a specific definition for the term “dependent.” *Id.*

84. For specific requirements for exemption from the California Act’s “fee,” see Sarah Heck Griffin & Brian T. Holmen, California Senate Bill 2 (Mar. 2004), <http://www1.jonesday.com/pubs/detail.asp?language=English&pubid=1153>.

employer's payroll.

Second, the California law makes direct reference to ERISA plans by discussing the minimum level of coverage due to avoid the fee. Although *Travelers Insurance* made significant changes to the Supreme Court's preemption analysis in the context of a law with a "connection with" ERISA plans, the decision seems to have left intact the strict analysis for state laws making "reference to" ERISA plans set forth in *Shaw* and *Greater Washington Board of Trade*. Recall that in the later case, the Court held that direct reference to ERISA plans was enough to trigger preemption.<sup>85</sup> There is no case law available to suggest that the California law would not have suffered the same fate.<sup>86</sup>

Finally, because the law prescribes specific benefits and administrative choices for plans to avoid the fee, it not only directly implicates the stated purpose of the ERISA preemption provisions, it also runs the risk of triggering the "acute . . . economic effects" exception to the indirect effects analysis set forth in the *Travelers Insurance* decision.<sup>87</sup> The Court stated in *Travelers Insurance* that the basic thrust of the preemption clause was to:

"minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."<sup>88</sup>

The California law presents that very risk by trying to strong arm plan sponsors into providing certain benefits that might not be mandated in some other state where the employer also does business. Furthermore, the scheme of "minimum benefits" mandated in order to avoid the fee is dangerously like the coercive methods discussed in *Travelers Insurance*, in which the Court wrote:

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85. See *supra* note 21 and accompanying text.

86. *Travelers Ins.*, 514 U.S. at 656 (citation omitted):

In *Shaw*, we explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." The latter alternative, at least, can be ruled out. The surcharges are imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the surcharge statutes cannot be said to make "reference to" ERISA plans in any manner.

87. *Id.* at 668 ("We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514.").

88. *Id.* at 656-57 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514.<sup>89</sup>

The result of the California law by both intent and likely by economic effect would have been precisely to “force” plans to “adopt a certain scheme of substantive coverage.” Thus, because of its punitive structure, its direct reference to health benefit plans and its mandate of minimum coverage, the California pay-or-play law would have likely triggered ERISA section 514 and been preempted.<sup>90</sup>

## 2. The Maryland Fair Share Health Care Act of 2005

The Maryland FSHCA, as it is currently drafted,<sup>91</sup> compels an employer with 10,000 or more employees in the state that fails to spend at least eight percent of payroll on “health insurance costs,” to pay the difference between what it does spend and the eight percent to the state Secretary of Labor to establish a state program for the working uninsured.<sup>92</sup>

The Maryland FSHCA is different from the Massachusetts Health Security Act (HSA) in a few important respects. First, the FSHCA conditions the imposition of the payroll tax on providing health care benefits to employees. However the employer chooses to spend the eight percent, the result is a health benefit plan covered by ERISA. If the law was read to mandate the creation and/or maintenance of employee benefit plans, it might be preempted as a law that “mandate[s] employee benefit structures or their administration.”<sup>93</sup> It seems unlikely that the FSHCA

89. *Id.* at 668.

90. For more commentary on the California Health Insurance Act of 2003, see *supra* note 50; Mark Hollmer, *Revival of ‘Pay-or-Play’ Health Bill Expected*, BOSTON BUS. J., Nov. 12, 2004; Tom Abate & Victoria Colliver, *Health Insurance Bill Revives National Debate*, SAN FRANCISCO CHRON., Oct. 3, 2003.

91. LR 1927 was passed by the Maryland state legislature on April 5, 2005. Governor Robert Ehrlich vetoed the bill on May 20, 2005. However, the veto was overridden on January 12, 2006. See *supra* note 10.

92. Unofficial copy of LR 1927 (FSHCA) § 8.5-104(B):

An employer that is not organized as a nonprofit organization and does not spend up to 8% of the total wages paid to employees in the State on health insurance costs shall pay to the Secretary an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 8% of the total wages paid to employees in the State.

§ 8.5-101:

This title applies to an employer with 10,000 or more employees in the State.

93. *Travelers Ins.*, 514 U.S. at 646.

would avoid ERISA preemption if it merely mandated that employers dedicate eight percent of payroll to employee health care coverage. What saves the FSHCA is the fact that it gives employers a choice between paying a state tax or dedicating the same funds to health care costs.

That “choice” between dedicating eight percent to health care costs or paying the difference to the state as a tax makes the FSHCA more analogous to a law having only a genuinely indirect effect on ERISA plans (like the hospital surcharges in *Travelers Insurance*) than the California law. If the indirect effect argument is accepted, it would be difficult to contend that the eight percent created an acute economic burden on ERISA plans when the employer sponsors can opt to pay the money as a tax to the state.

The strongest argument on behalf of the FSHCA is the fact that it refrains from any discussion of benefits or plan administration. Thus, whatever influence the Act might have on the percentage of payroll dedicated to health care benefits, it has no influence whatsoever over the structure of plans, the benefits offered, the eligibility of employees, and choices regarding providers.

*C. The Tax and Tax Credit Model: The Massachusetts Health Security Act of 1988*

In 1988, the Massachusetts legislature enacted the Health Security Act (HAS), which would have required employers with more than five employees to pay a payroll tax to finance a public health coverage program while providing a credit for the costs of any employee health benefits the employer actually funded (up to the tax liability).<sup>94</sup> The law did not refer to ERISA plans but only to employers; did not prefer whether employers

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94. Massachusetts Health Security Act, STAT. 1988. CHAPTER 23, MASSACHUSETTS LABOR AND INDUSTRIES CODE 151A section 14G (repealed):

subsection (b)

Each employer, except those employers who employ five or fewer employees, . . . shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, a medical security contribution for each employee computed by multiplying the wages paid each employee by twelve per cent. . . .

subsection (c)

An employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees, allowable for the current quarter by the Internal Revenue Service as a deductible business expense . . . such deduction for any employer shall not reduce the contribution for any employee below zero.

would “pay” the tax or “play” (by covering workers); and imposed no standards on the types of benefits offered, the amount the employer must pay, or any other plan features. Consequently, the Massachusetts law had no direct impact on the employer-sponsored plan, but rather was directed at the employer.

Because the HSA was repealed before it was implemented due to political pressures within the state, the ERISA preemption issue presented by the law was never litigated.<sup>95</sup> The obvious preemption challenge would have likely focused on the fact that the HSA would have forced employers (acting as plan sponsors) to evaluate their plans and modify them to minimize tax burdens. Whether this argument might have prevailed in the early 1990's, it seems unlikely to succeed in the wake of the *Travelers Insurance* decision. A state facing this argument could respond that the incentive a pay-or-play law gives a plan administrator to re-evaluate whether to pay the tax or provide coverage is no different from the incentive New York's differential hospital surcharges gives plan administrators to evaluate which type of insurance to buy. In the words of the Supreme Court's *Travelers Insurance* opinion, the state law incentive does not *bind* plan administrators to any particular choice.

Using the analysis mapped out in the Chart at the end of Part II, argumentation on behalf of an HSA-type pay-or-play law would proceed as follows:

(1) The HSA does not make *reference to* ERISA plans.<sup>96</sup>

(2) The HSA does indirectly affect ERISA plans by giving employers an incentive to provide health care benefits to employees.

(3) The HSA does not indirectly create such *acute* burdens on ERISA plans as to effectively restrain the choice of insurance providers or force plans to adopt certain schemes of benefits. The HSA, in fact, does not place any restrictions on the benefits provided or the insurers used. Furthermore, the HSA is effectively a system of tax and tax credit, allowing an employer to choose not to provide any health benefits whatsoever and shift that burden onto the state.<sup>97</sup>

(4) The payroll tax imposed by the HSA is a law of general applicability directed at employers and well within the states traditional

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95. The Massachusetts state restaurant association challenged the HSA but dropped the case when the law was repealed.

96. See discussion *supra* Part II.C.

97. See *supra* note 35.

powers to tax and protect the health and welfare of its citizens.<sup>98</sup>

Consequently, a law drafted like the Massachusetts Health Security Act should be defensible unless a court is willing to hold that the influence of an employer tax is so considerably more onerous than the provider tax at issue in the *Travelers Insurance* case that it rises to the level of an effective “restrain[t].” Because employers would choose to pay the tax or provide the benefits depending on which course of action would cost less, the pay-or-play program is likely to save money for an employer already offering coverage, making it harder to argue that the law imposes substantial costs on benefit plans. Of course, an employer not offering coverage would incur higher costs due to the tax, but since it had not previously operated a health plan, the new tax would not impose costs on a plan.<sup>99</sup> Conversely, if covering workers would cost the employer less than the tax (factoring in good will, etc.), then it could be argued that the HSA influences employers to establish ERISA plans. However, this influence would have to rise to the level of a substantial burden since it neither addresses ERISA plans nor places any conditions on coverage or administration decisions.

## V. CONCLUSION

A state “pay-or-play” program designed like the Massachusetts Health Security Act of 1988 (imposing a tax on all employers as one source of revenue to finance a public health coverage program but crediting against the tax the cost of any coverage provided to employees and dependents) is most likely to survive scrutiny under courts applying Supreme Court ERISA preemption jurisprudence. The Maryland Fair Share Health Care Act of 2005 also seems to successfully get over the major preemption hurdles left in play after the *Travelers Insurance* decision. Given the

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98. General applicability has saved other state laws with an indirect effect on benefit plans from preemption by ERISA section 514(a). For example, in *De Buono v. NYSA-ILA Medical & Clinical Service Fund*, 520 U.S. 806 (1997), the Supreme Court held that New York’s Health Facility Assessment (HFA), which imposes a tax on gross receipts for patient services at, inter alia, diagnostic and treatment centers, “is not pre-empted because it is a tax of general application having only an incidental impact on benefit plans.” *Id.* at 806.

99. I must concede that this point can be countered with the analysis of general state mandates discussed in Part IV.A. What distinguishes the mandate from the choice at issue with a pay-or-play law is that the mandate gives the employer the choice between creating a benefit plan where there was none before or maintaining or adding to an existing benefit plan whereas the pay-or-play model gives the employer the choice between creating or maintaining a benefit plan and paying a tax. In the case of the former, either choice involves benefit plans. In the case of the later, one choice, paying a tax, does not involve benefit plans. Thus the pay-or-play law can be complied with without any effect on employee benefit plans.

semantic wrestling in which the Court in *Travelers Insurance* was willing to engage in order to open the door for more state experimentation with health care solutions, it seems fair to suggest that the FSHCA would not be interpreted like a general health coverage mandate. However, the Massachusetts statutory scheme more efficaciously avoids any interpretation as an employer mandate by establishing a simple system of tax and tax deduction.

In 2002, the National Academy for State Health Policy made a series of recommendations for pay-or-play law design features that could serve to avoid ERISA preemption.<sup>100</sup> Both the Maryland Fair Share Health Care

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100.

(1) DO NOT REQUIRE EMPLOYERS TO OFFER HEALTH COVERAGE TO THEIR WORKERS. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

(2) ESTABLISH A UNIVERSAL COVERAGE PROGRAM FUNDED IN PART WITH EMPLOYER TAXES. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

(3) DO NOT REFER TO ERISA PLANS. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

(4) REMAIN NEUTRAL REGARDING WHETHER EMPLOYERS OFFER HEALTH COVERAGE OR PAY THE TAX. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

(5) IMPOSE NO CONDITIONS ON EMPLOYER COVERAGE TO QUALIFY FOR THE TAX CREDIT. Despite the state's concerns about adequacy of benefits packages, cost-sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

(6) MINIMIZE ADMINISTRATIVE IMPACTS ON ERISA PLANS. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover the workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to



Law and the Massachusetts Health Security Act comply with all six recommendations. Since *Travelers Insurance*, the Supreme Court has narrowed ERISA's preemptive reach to provide states more flexibility to regulate health care in the glaring absence of substantive federal regulation.<sup>101</sup> The pay-or-play laws are the most recent non-insurance regulation to test the scope of ERISA preemption. In fact, as of June 2005, at least eight states have drafted legislation similar to the Maryland Fair Share Health Care Act requiring employers to provide health care benefits to their workers or pay the state through various means to help the uninsured.<sup>102</sup> Because no court has yet had the opportunity to consider a state pay-or-play law, such programs, if enacted, are likely to be challenged. However, those programs designed like the Maryland or Massachusetts laws should survive such a challenge.

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varying state tax systems.

BUTLER, REVISITING PAY OR PLAY, *supra* note 9, at 6–8. Reprinted with the permission of the NASHA.

101. See *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). The Supreme Court upheld Kentucky's Any Willing Provider (AWP) law, KY. REV. STAT. ANN. §§ 304.17A-171(2), 304.17A-270 (West 2005), requiring a health insurer to acknowledge the services of any healthcare provider willing to abide by the insurer's plan thereby indirectly imposing certain providers and attendant costs on employee benefit plans governed by ERISA. *Id.* at 335; see also *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 372 (2002) (upholding Illinois' "external review" law, which provides an independent appeal mechanism for HMO enrollees to dispute benefit denials). "The Court held that ERISA did not preempt the external review law because, among other criteria, the law applies only to insurers and, by adding an extra layer of review for enrollee benefit disputes, regulates an integral part of the policy relationship between HMOs and their enrollees." BUTLER, ANY WILLING PROVIDER, *supra* note 50, at 4.

102. See *supra* note 6 and accompanying text.